ATRANS APPLICATION
Certification of ADA Paratransit Eligibility

Instructions: PLEASE READ CAREFULLY and remove this sheet before returning the application.

The following information is provided to assist you in completing the attached application for paratransit service from ATRANS. Please note that eligibility is not based on a person's age. This application is divided into three sections listed below:

Policies and Procedures **KEEP this part for your records. DO NOT return this part to ATRANS.**
Part 1 Applicant Information
Part 2 Health Care Professional Verification

- Please complete the **entire** application and return Parts 1 & 2 to ATRANS. We will contact you if the application is incomplete or have additional questions. Print clearly in ink and return the original application to ATRANS. Copies and faxes are not accepted.

- Part 2 is **ONLY** for the health care professional familiar with your disability. The application will be returned to you if anyone other than the health care professional answers. A licensed health care professional must be licensed by the state of Louisiana and may include, but is not limited to, a physician, nurse, or vocational rehabilitation counselor. **NO SOCIAL WORKERS**

- Signatures are required from all applicants or their legal guardians on the application. Also, health care professionals must include their signature.

- Allow three (3) weeks for completed applications to be processed. ATRANS will determine if you are eligible for this service and notify you by mail of our decision.

- ATRANS and the Federal Transit Administration to provide public transit services will use the information obtained in this certification. This information will be confidential and will not be provided to anyone else.

- You may contact our Eligibility Office at (318) 441-6087

Send your completed application to:
City of Alexandria, LA - ATRANS P.O. Box 71, Alexandria LA 71309-0071

Information obtained in this certification process will only be used by ATRANS for the provision of transportation services. Information will only be shared with other transit providers to facilitate travel in those areas. The information will not be provided to any other person or agency.

NAME: _____

HOME ADDRESS: _____

MAILING ADDRESS: _____

TELEPHONE NUMBER:_____WORK TELEPHONE NUMBER: _____

DATE OF BIRTH: _____

WHAT IS THE DISABILITY WHICH PREVENTS YOU FROM USING THE FIXED ROUTE SERVICE?

IS THIS CONDITION TEMPORARY? Yes ☐ No ☐

IF YES, EXPECTED DURATION UNTIL: _____

HOW DOES THIS DISABILITY PREVENT YOU FROM USING FIXED ROUTE SERVICES? (**Please explain completely and attach another sheet of paper if more space is needed.**)

The following information will be used to ensure that an appropriate vehicle is utilized to provide your transportation and that an accurate analysis of your trip requests can be made by ATRANS.

DO YOU USE ANY OF THE FOLLOWING MOBILITY AIDS? ***(Check all that apply)***

POWERED SCOOTER ☐ CRUTCHES ☐ CANE ☐

MANUAL WHEELCHAIR ☐ ELECTRIC WHEELCHAIR ☐

PERSONAL CARE ATTENDANT ☐ GUIDE DOG ☐

OTHER (Please specify):

DO YOU REQUIRE A PERSONAL CARE ATTENDANT WHEN YOU TRAVEL? Yes ☐ No ☐

IF YES, NAME OF CERTIFIED PERSONAL CARE ATTENDANT:

CAN YOU TRAVEL 200 FEET WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes ☐ No ☐

CAN YOU TRAVEL 1/4 MILE WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes ☐ No ☐

CAN YOU TRAVEL WITHOUT THE ASSISTANCE OF ANOTHER PERSON? Yes ☐ No ☐

CAN YOU CLIMB THREE 12 INCH STEPS WITHOUT ASSISTANCE? Yes ☐ No ☐

CAN YOU WAIT OUTSIDE WITHOUT SUPPORT FOR TEN MINUTES? Yes ☐ No ☐

HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS CORRECT.

SIGNATURE_____ DATE _____

IF THIS APPLICATION HAS BEEN COMPLETED BY SOMEONE OTHER THAN THE PERSON REQUESTING CERTIFICATION, THAT PERSON MUST COMPLETE THE FOLLOWING:

NAME: _____

ADDRESS: _____

DAY-TIME TELEPHONE NUMBER: _____

SIGNATURE: _____

To the Applicant: Sign below to allow the release of information from the professional who will be filling out this form. Once complete, return the form with your completed ADA Application.

I hereby request that information pertaining to my functional limitations be released to ATRANS, for further determination of my ADA paratransit eligibility.

Applicant Name:_____

Applicant Address:_____

X Applicant Signature:_____Date: _____

To the person filling out the form:

This form must be filled out by a professional who is knowledgeable about the applicant's capabilities and treating the individual for the disability that prevents them from using ATRANS (i.e. physical disability should be described by a Physician, OT, PT. Etc). Please check the appropriate box for the person completing this form.

☐ Vocational Rehabilitation Counselor	☐ O & M instructor
☐ Licensed Social Worker	☐ Physician
☐ Senior Program Director	☐ Physical Therapist
☐ Respiratory Therapist	☐ Occupational Therapist
☐ Psychologist	☐ Mental Health Counselor
☐ Psychiatrist	☐ Other _____

Please provide information regarding the disability and its impact upon the ability to utilize our transit services. The information you provide will allow us to make an appropriate evaluation of this request and its application to specific trip requests.

Please assist us in our determination process by providing the following additional information about the applicant named above. All information will be kept confidential.

1. What is your relationship with the applicant: _____

2. Medical Diagnosis of condition causing disability._____

3. Is the applicant's disability temporary? ☐ No ☐ Yes ☐ 3-6 mo. ☐ 6-9 mo ☐1yr/more

   If YES, expected duration until:_____

4. Is this person: (Check Y or N)

   - Able to travel 200 feet without the assistance of another person? ☐ Yes ☐ No
   - Able to travel ¼ mile without the assistance of another person? ☐ Yes ☐ No
   - Able to travel without the assistance of another person? ☐ Yes ☐ No
   - Able to climb three 12 inch steps without assistance? ☐ Yes ☐ No
   - Able to wait outside without support ten minutes? ☐ Yes ☐ No

5. Does this person use any mobility aids? ☐ Yes ☐ No

   If yes what? _____

6. Visual Acuity with Best Correction:

   Right Eye☐ Left Eye☐ Both☐

7. Visual Fields:

   Right Eye☐ Left Eye☐ Both☐

8. Is this person able to: (Check Y or N)

   - Give address and telephone number upon request? ☐ Yes ☐ No
   - Recognize a destination or landmark? ☐ Yes ☐ No
   - Deal with unexpected situation or changes in routine? ☐ Yes ☐ No
   - Understand and follow directions? ☐ Yes ☐ No
   - Safely travel through crowded complex facilities? ☐ Yes ☐ No

9. Is there anything other effect of the disability of which ATRANS should be aware? _____

   _____

I certify that the information contained in this application is true and correct to the best of my knowledge and ability.

Signature_____***Date***:_____

Print Name _____

Professional Title_____

Clinic/Agency_____

Phone _____

Address_____***City***_____***Zip*** _____